Medicaid: Containing Costs & Improving Quality

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Medicaid: From Welfare Program to Health Insurer

- 1965 – afterthought to Medicare; tied to welfare
- 1996 – welfare reform delinks Medicaid and cash assistance
- 2010 – most Medicaid beneficiaries work or are family members of workers
- 2010 – 60 million Americans enrolled; one quarter of uninsured eligible, but not enrolled
- 2014 – national eligibility level (133% of FPL); 16 million more people eligible
- 2019 – nation's single largest insurer, covering 25% of population

New Culture of Coverage: Requires Easy Enrollment & Renewal Processes

- Single application for Medicaid and premium tax credits through Exchange
- Screen and enroll for Medicaid and Exchange
- Single or connected enrollment websites for Medicaid and Exchange
- Electronic interfaces and data matches to verify eligibility at enrollment and renewal

Take up rates will go up and churning will go down

New enrollees will be primarily single adults

Record Enrollment Growth Today Putting Pressure on State Budgets

- Recession leading to record enrollment growth
- 48 states facing budget shortfalls totaling $194 billion
- Medicaid largest or second largest item in every state budget
- ARRA enhanced FMAP ends
- $1.4 trillion federal deficit makes additional federal support unlikely

States Need Sound Cost Containment Strategies

- Eligibility cuts are not available
- Across the board rate cuts secure immediate savings, but pose short and long term problems
  - Access
  - Quality
  - Legal
- Payment and system reforms offer opportunity to cut costs while improving quality and positioning state for federal reform
  - For Medicaid patients
  - For all patients

Federal Law Requires Sound Payment Policies

Medicaid payments must be *"consistent with efficiency, economy, and quality of care and… sufficient to enlist enough providers so that care and services are available [to Medicaid enrollees] at least to the extent that such care and services are available to the general population in the geographic area…."* 42 U.S.C. 1396a(a)(30)A

States select payment methods and levels, and CMS approves

Effective and Sustainable Medicaid Payment Reform

- Produces immediate *savings*
- Creates a sound payment system that enables *access*, and incentivizes providers to adopt more *efficient* and *effective* delivery models
- More likely, when payers are aligned

FFS Payment Fundamentals Matter… A Great Deal

- FFS is not going away any time soon
- FFS payment methods and levels drive efficiency and access or the lack thereof
  - Cost-based rates discourage efficiency and encourage higher charges
  - Fee schedules and per diem rates incentivize volume
  - Both absolute and relative payment levels influence access
- FFS payments are the building blocks of payment reform

State Medicaid Programs Have Implemented Multiple Payment Reforms

- 46 states have more than half their enrollees in managed care
  - Most spending still FFS
- 30 states have advanced medical home initiatives
- 11 states have adopted non-payment policies for hospital acquired conditions

Targeting Potentially Preventable Readmissions: Measurable Savings and Improved Quality

- PPRs are return hospitalizations that result from the process of care and treatment or lack of post discharge follow-up rather than unrelated events that occur post discharge.
- AHRQ found that 1 in 10 adult Medicaid patient who were hospitalized for a hospital condition in 2007 other than child birth had to be readmitted at least once within 30 days.
- Medicaid patients 70% more likely to be readmitted than privately insured counterparts.

Designing a Hospital Specific Payment Adjustment for PPRs

- Identify readmissions that are potentially preventable
- Apply risk adjustment to potentially preventable hospital readmission rates
- Compare risk adjusted readmission rates of hospitals
- Establish the magnitude of hospital specific payment impacts
- Incorporate payment adjustment into payment system

Targeting Medically Complicated Populations: Measurable Savings and Improved Quality

- Top 4% beneficiaries have 50% of spending
  - Among the most expensive 1% Medicaid beneficiaries (acute care only) 80 % have 3 or more chronic conditions
- Dual eligibles equal 14% of Medicaid enrollment and drive 44% of total spending

… and most are in unmanaged fee-for-service

Managing the Care and Costs of Complex Populations

- Fully capitated arrangements with health plans
  - Plan is paid a monthly fee for each enrollee
  - Plan is at risk for all services covered by fee
  - Financial incentive should encourage primary care and early identification and treatment of health problems
  - Offers cost predictability and mechanism to assess and improve quality
- Fee-for-service plus care management arrangement with providers
  - Provider usually paid FFS
  - Care management fee and/or bonus or shared savings for reduced admissions andED visits
  - Care management at provider rather than plan level may work better for more complex populations
  - Attractive in rural areas where fewer plans

Some Specific Cost Containment Opportunities

- Integrated care for dual eligibles
  - At state
  - At plan
- Predictive modeling to identify high-opportunity patients and tailor interventions
  - Medication therapy management
- Utilization management through retrospective and concurrent reviews
- Focus on personal responsibility

Federal Health Reform Supports State Strategies to Reduce Costs and Improve Quality

- 100 percent FMAP to increase primary care rates for two years
- Health homes for enrollees with chronic conditions
  - 90 percent FMAP for 2 years
- Demonstrations for bundled payments and ACOs
- Grants/contracts for community health teams to support medical homes
- Grants/contracts for medication management in treatment of chronic disease
- Grants for state to provide incentives to Medicaid beneficiaries to participate in programs to prevent chronic disease
- Center for Medicare and Medicaid Innovations pilots to test payment and system reforms
- Federal Coordinated Health Care Office for dual eligibles